2006 LEA Medi-Cal Billing Option Program Training
Frequently Asked Questions (FAQs)

Topics

I. *Assessment Policy and Billing*

Q1. When an IEP/IFSP health assessment takes more than one day to complete, should we bill for a new assessment each day or for one assessment over the course of two days?

A. For IEP/IFSP encounter-based assessments (physical therapy, occupational therapy, speech-language, audiological, health, and psychological), you will bill only one unit of service regardless of the amount of time it takes to complete the assessment. When billing for an assessment that takes multiple days to complete, use the "from-through" billing method to record the dates over which the assessment was conducted. If the assessment is completed on a single day, the "from-through" billing method is not required and LEAs may record the date of service on which the assessment was completed. The encounter-based rate has been developed to incorporate, among other tasks, preparation time, direct service time, and report writing time that occur over the course of the assessment, whether the assessment takes one day or several days to complete.

Q2. For our IFSP students (birth to age three), we do the initial, annual and a six-month/periodic review, as required by law. How do we bill for these services within the new program structure?

A. The new structure allows for three types of assessments: initial/triennial, annual and amended.

- Initial/triennial assessments may be billed once every third fiscal year;
- Annual assessments may be billed in the year when an initial/triennial is not performed; and
- Amended assessments may be billed when performed to amend an initial, triennial or annual assessment that was performed in that fiscal year.

In this example, the six-month assessment would be considered an amended assessment.

Q3. How do we bill for services required to be delivered per the IEP? For example, if the IEP calls for quarterly vision or hearing assessment of a student, can these services be billed as treatment services, assuming the LEA meets the minimum time increments?

A. No. Only one follow-up assessment is billable per fiscal year. In this case, your LEA could bill the first re-assessment as an amended assessment in addition to the initial/triennial/annual assessment conducted that fiscal year. The remaining quarterly assessments would not be billable, based on the new utilization controls.

Q4. When conducting an annual assessment, certain information comes from the parent, and not necessarily from contact time with the student. Is this billable as an annual assessment?

A. No, parent/guardian meeting time alone is not billable as an annual assessment. Required components of an annual assessment include:

- Review student records, such as cumulative files, health history, and/or medical records;
- Interview student and/or parent/guardian;
- Observe student in appropriate settings; and
- Write a report to summarize assessment results and recommendations for LEA services.

During an annual assessment, administration and scoring/interpreting of tests may or may not be included, depending on the needs of the student. However, direct student contact service time is required. In addition, documentation is required to support that you have met the requirements of the assessment.

Q5. Which assessments can utilize the rounding policy?

A. You cannot round up time spent to conduct assessment services. Assessments may only be billed for <u>completed</u> service time. The rounding policy applies to treatment services that are:

- Billed in 15-minute increments (nursing, trained health care aide and TCM services); or
- Additional 15-minute increments provided beyond the initial 15-45 minute treatment session (physical therapy, occupational therapy, individual and group speech therapy, audiology, and individual and group psychology and counseling).

Q6. If a registered credentialed school nurse performs a hearing screening as part of a health assessment, can it be billed separately?

A. All of the tests and procedures that are performed by a registered credentialed school nurse as part of a health assessment are reimbursable under one procedure code and maximum allowable rate. Under the new program structure, your LEA cannot bill for separate assessment components.

Q7. If an IEP student receives an initial speech assessment in English and a second speech assessment in Spanish, can both assessments be billed as initial assessments under the LEA Program? What if two practitioners perform the initial assessment?

A. No. Initial and triennial IEP/IFSP assessments are limited to one every third fiscal year per provider per assessment type. This means that if more than one initial/triennial speech

assessment is billed under your LEA's provider number before the third fiscal year, the second claim will be denied.

II. *Treatment Service Policy and Billing*

Q8. For non-IEP/IFSP students, can we bill the LEA Program for services rendered under a Section 504 Plan?

A. No. You may not bill Medi-Cal for services provided under a Section 504 Plan.

Q9. There is an annual service limitation of 24 services per 12-month period for non-IEP/IFSP services; if we transport a student to a therapy service, does that transportation count as one of 24 services in a 12-month period?

A. Yes; each non-IEP/IFSP assessment, treatment and transportation service is included in the 24 services per 12-month period limitation. In addition, Free Care requirements must be met in order to bill for non-IEP/IFSP services.

Q10. Does rounding for treatment services only apply to nursing and school health aide treatments?

A. The rounding policy applies to two billing increment scenarios: (1) Treatments and TCM that are billed in 15-minute increments (nursing, school health aide, TCM); and (2) *Additional 15-minute treatment service increments* beyond the initial 15-45 minutes (physical therapy, occupational therapy, group and individual speech therapy, audiology, and group and individual psychology and counseling). The rounding policy does not apply to any assessment services.

Q11. If we have an aide who is constantly accompanying an IEP/IFSP student and assessing or monitoring their medical condition, can we bill for the time when the aide is not providing direct medical care? For example, if an aide accompanies a student who must be constantly monitored for suctioning, can this monitoring time be billed?

A. Yes, an LEA can bill for an IEP/IFSP student to receive constant monitoring as part of direct medical service if it is medically necessary and authorized in the IEP/IFSP.

Q12. Under nursing services, a student is often observed to determine whether they need a treatment service. After the treatment is provided, the student continues to be observed to assess whether the treatment was successful. For example, a nurse provides suctioning as authorized in the IEP/IFSP, and continues to monitor the student after the treatment. Can the observation time prior to and after the treatment be billed as part of the direct service time to meet the seven minute minimum time period?

A. Yes. Medically necessary observation of a student as part of a direct medical service may be billed.

Q13. Under nursing services, do we need to have a frequency attached to the service in the IEP? Many times the nurses will provide services on an as-needed basis, which is reflected in the IEP. Is this acceptable?

A. Nursing services may be authorized on an as-needed basis in the IEP/IFSP, as appropriate to the diagnosis. For certain medical conditions, physicians may authorize that services should be provided as required or needed. As long as the LEA maintains documentation that as-needed services are medically necessary, these services may be billed to Medi-Cal.

Q14. How long is a prescription/referral/recommendation for treatment services valid?

A. Prescriptions, referrals and recommendations must be updated annually.

Q15. What constitutes a non-IEP/IFSP health education/anticipatory guidance assessment under the new program?

A. Health education/anticipatory guidance is preventative medical counseling and/or risk factor reduction provided to an individual/parent based on an evaluation of the individual's needs, and provided as a direct face-to-face service. When this service is provided to a non-IEP/IFSP student, the Free Care requirements must be met.

Q16. How do you bill medical counseling (previously billed as a health education/anticipatory guidance service) for IEP/IFSP students?

A. Although there is no specific billing code for health education/anticipatory guidance provided to an IEP/IFSP student, medical counseling may be provided by an appropriate practitioner as a treatment service within their scope of practice. For example, if a school nurse is providing nutrition counseling to an IEP student with an eating disorder per their IEP, this may be billed as part of the nursing treatment service.

Q17. Is health education/anticipatory guidance reimbursable under the LEA Program if the service was provided by telephone?

A. No, health education/anticipatory guidance is preventative medical counseling and/or risk factor reduction provided to an individual/parent based on an evaluation of the individual's needs, and provided as a direct face-to-face service.

Q18. Are there a maximum number of students for "group" treatments? In the current program, a group is defined as two to eight students.

A. To bill for group speech therapy or psychology and counseling services under the new national codes, a group must be two or more students, but not more than eight students.

Q19. Are toileting, diapering and lifting reimbursable under the LEA program if those services are documented as medically necessary in the student's IEP?

A. Diapering, toileting and lifting are considered personal care services, which are not covered in California's Medicaid State Plan. Therefore, these services are not currently reimbursable under the LEA Program. Personal care services may not be billed as nursing treatment services under any circumstance, even if prescribed by a physician and included in an IEP.

III. *Prescriptions, Referrals, Recommendations and Protocol*

Q20. Would an electronic version of a prescription, referral or recommendation be acceptable in place of a hard copy document?

A. Electronic prescriptions, referrals or recommendations are acceptable only if there are processes in place to ensure that the prescription, referral or recommendation is provided by a valid, appropriate and qualified practitioner and includes an electronic signature. However, hard copies of a these forms must be maintained for at least three years.

Q21. When the parent signs the parental consent portion of the Assessment Plan, is this form adequate to document a parental request for assessment services?

A. No. A parent, teacher or school nurse request for assessment requires specific documentation of the observations and reason for the assessment. A parent signature on an Assessment Plan is not adequate documentation under the LEA Program requirements. LEAs may be able to modify documentation they currently use to incorporate the information required when a parent requests an assessment service.

Q22. Is there a required format for the prescriptions, referrals or recommendations?

A. Although there is no mandated format for this documentation, minimum requirements have been established in the LEA Training Workbook, Section I. Your LEA must ensure the required information is included to adequately document the medical necessity for services.

Q23. When can a physician-based standards protocol be used to establish medical necessity?

A. A physician-based standards protocol may be developed by your LEA and used to document the medical necessity of speech and audiology treatment services to meet California State requirements that a written referral be provided by a physician or dentist prior to rendering speech and audiology treatment services. However, according to federal law (42 CFR 440.130(c)), a written referral from a physician or other licensed practitioner of the healing arts within the practitioner's scope of practice is required to document medical necessity of speech and audiology treatment services. LEAs must meet both State and federal documentation requirements. Note that this information differs from what is included in your training workbook. At the end of the Spring 2006 training sessions, CMS provided clarification that the physician-based standards protocol does not meet federal requirements for documenting medical necessity of speech and audiology treatment services. CMS clarified that a physician or other licensed practitioner of the healing arts (i.e., licensed speech-language pathologist or licensed audiologist) must refer the student for speech and audiology treatment services.

Q24. Will CDHS provide the physician-based standards protocol cover letter for the LEA providers?

A. No, your LEA must develop and maintain its own physician-based standards protocol. The protocol may only be used to meet State requirements documenting medical necessity for speech and audiology treatment services. The protocol does not fulfill federal requirements as defined in 42 CFR 440.130(c), and noted in the answer to Question 23.

Q25. Is it necessary to have a prescription, referral or recommendation from a health services practitioner to provide assessment services?

A. The prescription, referral or recommendation for an assessment must be documented in one of two ways: your LEA can obtain an individual written prescription, referral or recommendation from an appropriate health services practitioner; or a referral by a parent, teacher or credentialed school nurse. Regardless of which option is used, the required documentation must be located in the student's files.

Q26. Can an occupational therapist prescribe treatment services based on his/her assessment?

A. The occupational therapist conducting the assessment may determine the need for treatment services. However, State regulations require a written prescription by a physician or podiatrist,* within the practitioner's scope of practice, to bill for occupational therapy treatment services in the LEA Program.

* Note that if you were a Downey or Oakland training attendee, this language is slightly different from the information in your training workbook. At the end of April 2006, CMS provided clarification that a dentist is not an acceptable practitioner to provide a prescription for OT or PT treatment services.

Q27. For IEP/IFSP students receiving treatment services, prescriptions, referrals and recommendations may be established in the IEP/IFSP. What does this mean?

A. For treatment services, the appropriate health service practitioner(s) may record the prescription, referral and/or recommendation for treatment services directly in the child's IEP/IFSP or as a separate document that is attached to the IEP/IFSP.

Q28. Can a registered credentialed school nurse self-refer a student for a health assessment?

A. Yes, a registered credentialed school nurse can self-refer since they are one of the practitioners listed as qualified to refer for assessment services. If a self-referral is made, the practitioner must still include the appropriate documentation in the student's file, outlined in Section I of your training Workbook.

IV. *Supervision Requirements*

Q29. Can a certified public health nurse employed by an LEA supervise licensed vocational nurses (LVN) and trained health care aides?

A. No, LVNs and trained health care aides providing specialized health care services must be supervised by a licensed physician, registered credentialed school nurse or certified public health nurse employed by the State Department of Health Service. Although a certified public health nurse may be employed by an LEA to provide specialized physical health care services, that public health nurse is not qualified to supervise a LVN or trained health care aide who provides specialized health care services.

Q30. My LEA has a credentialed speech-language pathologist with 20 years of experience. Does the licensed speech-language pathologist still have to supervise this practitioner? What kind of supervision is required?

A. Yes. Regardless of the years of experience a credentialed speech-language pathologist may have, he or she must be supervised by a licensed practitioner. In addition, the supervising licensed practitioner must see each student at least once, have some input into the type of care provided, and review the student after treatment has begun. The supervising licensed speech-language pathologist should periodically: observe assessments, evaluation and therapy; observe the preparation and planning activities; review student records; and monitor and evaluate assessment and treatment decisions of the credentialed speech-language pathologist. Supervision should be appropriate to the level of experience of the credentialed practitioner. These supervision requirements are also applicable to credentialed audiologists, who must be supervised by licensed audiologists.

V. *Free Care and Other Health Coverage*

Q31. Can vision and hearing screenings mandated during the statewide periodicity schedule be billed to Medi-Cal?

A. State mandated screenings (including vision, hearing and scoliosis testing) may never be billed to Medi-Cal.

Q32. Does my LEA need to pursue Other Health Coverage (OHC) prior to billing Medi-Cal for both IEP and non-IEP students?

A. Yes. For services authorized in a student's IEP/IFSP, Medi-Cal is still the "payer of last resort" to the student's private third party insurance coverage. If an IEP/IFSP student has third party insurance, your LEA must pursue OHC prior to billing Medi-Cal. For services *not* authorized in the student's IEP/IFSP, or for students without an IEP/IFSP, your LEA must additionally meet all Free Care requirements before billing Medi-Cal. This would include establishing a fee schedule, obtaining third party insurance information for the entire population receiving the service (Medi-Cal and non-Medi-Cal students), and billing OHC prior to billing Medi-Cal.

Q33. My LEA provides IDEA services to a student with OHC. Do I need individual parental consent to bill OHC, prior to billing Medi-Cal?

A. Although there is language in the Medi-Cal Application that assigns third party recovery to the State, this agreement is between the beneficiary and the State of California. The LEA is not part of this agreement, and must obtain separate parental consent to bill OHC prior to billing Medi-Cal.

Q34. How can my LEA find out whether a student has Other Health Coverage (OHC)?

A. OHC information is available through the eligibility tape match.

Q35. If an IEP/IFSP student receives an additional vision assessment outside of the State mandated vision assessment schedule, will that supplementary vision assessment be reimbursed through the LEA Program?

A. LEAs may only bill additional vision assessments outside of the mandated schedule for an IEP/IFSP student as part of a health assessment. One initial/triennial IEP/IFSP health assessment is billable every third fiscal year. In the intervening year, an annual health assessment may be conducted. One amended assessment may be billed each fiscal year in which an initial, triennial or annual assessment is conducted. The supplementary vision assessment may be conducted as part of the initial/triennial, annual, or amended assessment, but is not separately billable.

Q36. What is the difference between the Free Care requirement and the Third Party Liability (TPL) requirement?

A. The Free Care requirement and the TPL requirement are separate, yet interrelated requirements. The Free Care requirement is based on the basic premise that Medicaid funds may not be used to pay for services that are available without charge to everyone in the community. Free Care, or services provided without charge, are services for which there is no beneficiary liability and for which there is no Medicaid liability. In order for the services not to be considered "free", the following conditions must be met:

- A fee schedule is established for the services provided (this can be a sliding scale to accommodate individuals with low income);
- The LEA has determined whether every individual served has any third-party benefits (other health coverage), and
- The LEA bills the beneficiary and/or any third parties for reimbursable services.

For purposes of the provision of school-based health services, there are two exceptions to the Free Care rule: (1) Medicaid-covered services provided as part of an IEP/IFSP, and (2) services provided by Title V of the Social Security Act (Title V of the Act is the Maternal and Child Health Services Block Grant).

The TPL requirement is based on the basic premise that under Medicaid law and regulations, Medicaid is generally the payer of last resort. For this reason, even if services provided as part of an IEP/IFSP are exempt from the Free Care rule, they are not exempt from the TPL requirement. If any student (including those with an IEP/IFSP) has Other Health Coverage (OHC), those third party insurers must be billed prior to billing Medi-Cal for the service.

For more information on the Free Care rule or the TPL requirement, refer to the 1997 *Medicaid and School Health: A Technical Assistance Guide*, posted on the LEA Program website.

Q37. To meet the Free Care and Other Health Coverage (OHC) requirements, can an LEA bill a claim to Medi-Cal after billing OHC, but before it has been processed by OHC?

A. No, your LEA must receive a valid denial of non-coverage from OHC prior to billing Medi-Cal. The CMS' *Medicaid and School Health: A Technical Assistance Guide* (1997) provides additional guidance regarding OHC requirements. This document is available on the LEA Program website at www.dhs.ca.gov/lea.

Q38. Can my LEA bill for services rendered to non-IEP students if one parent refuses to provide Other Health Coverage (OHC) information?

A. No, if one parent refuses to provide OHC information, the care is considered "free" and cannot be billed to Medi-Cal.

Q39. If a non-IEP/IFSP child is referred for a vision assessment outside of the State mandated periodicity schedule, can Medi-Cal be billed?

A. If the vision assessment is not provided on the State mandated periodicity schedule, it may qualify for Medi-Cal reimbursement if the Free Care requirements are met.

VI. *New Procedure Codes and Modifiers*

Q40. Will EDS or CDHS provide assistance to LEAs in order to set up changes to their software systems?

A. No, EDS and CDHS do not have the resources to help LEAs to implement changes to their software systems. EDS regional representatives are available for on-site visits to assist LEAs with billing-related issues, but they will not offer technical support on modifying software systems.

Q41. If my LEA submits a claim after July 1, 2006 using the current codes for a service that was provided prior to July 1, 2006, do we have to fulfill the new program requirements or the current requirements?

A. As of July 1, 2006, claims with dates of service between July 1, 2005 and June 30, 2006 may be billed with either current or new codes. Claims with dates of service in this time period that are billed with the current codes must meet the current State and federal requirements; claims with dates of service in this time period that are billed with new codes must meet the new State and federal requirements.

Q42. If the date of service occurred before July 1, 2006, does my LEA bill using the current codes or the new codes if the claim is submitted after July 1, 2006?

A. Claims billed on or after July 1, 2006 with dates of service prior to the implementation of the new codes may be billed with the current codes or the new codes, subject to timely filing of claims penalties. Claims with *dates of services* on or after July 1, 2006 *must* be billed with the new codes.

Q43. Will a claim be denied if we include a practitioner modifier when one is not required? For example, on a nursing treatment service, if a claim is inadvertently submitted with T1002TD (when the required coding is T1002), will the claim deny?

A. An extraneous modifier will not cause the claim to deny. If the claim has an unnecessary modifier with a procedure code which does not require modifiers, the claim will process as long as it does not have any other significant problems, such as a mistyped recipient number, date of service issue, etc.

VII. *Contracted Practitioners*

Q44. My school district is part of an LEA collaborative that bills under one provider number and shares a school nurse. My school district is responsible for paying the salary and benefit expenses of the nurse. The remaining member school districts in the collaborative contract for this nurse's services. Given this situation, can all collaborative members still bill for the nurse's services under one provider number?

A. Yes. Since LEAs participating in a billing collaborative are all billing under a single Medi-Cal provider number, collaborative members may bill for services provided by an employee of one of the collaborative members, regardless of which school district in the collaborative employs the practitioner.

VIII. *Rendering Practitioner Qualifications*

Q45. If one of my special education teachers has the educational and credentialing requirements of a direct-care practitioner, can I bill Medi-Cal for direct health services provided by this person? For example, can my special education teacher who meets the requirements of a Program Specialist bill for Targeted Case Management (TCM) services?

A. The job title does not need to match the LEA qualified rendering practitioner title, so long as the person providing a direct health service meets the educational and program credentialing requirements for billing under the LEA Medi-Cal Billing Option. In this example, your LEA may bill for TCM services rendered by a special education teacher who meets the qualifications of a Program Specialist.

Q46. Are services provided by occupational therapy assistants, speech therapy assistants or physical therapy assistants reimbursable under the LEA Program?

A. No, therapy assistants are currently not qualified practitioners under the LEA Program.

IX. *Targeted Case Management (TCM) Policy and Billing*

Q47. How often does my LEA have to submit the TCM Labor Survey in order to bill for TCM services? Do TCM services need to be in the IEP?

A. You must complete the Labor Survey only once, prior to billing for TCM services. The Labor Survey is available for download on the LEA Program Website. TCM is only billable for IEP/IFSP students, and must be authorized in the IEP/IFSP.

Q48. Can my LEA bill Medi-Cal Administrative Activities through the MAA Program and LEA Targeted Case Management (TCM) services?

A. There is some overlap between Medi-Cal Administrative Activities through the MAA Program and LEA TCM services. Regardless of whether you bill Medi-Cal Administrative Activities through the MAA Program or TCM services through the LEA Program, you may not bill more than once for the same service. If your LEA is billing Medi-Cal Administrative Activities through the MAA Program, please refer to the California School-

Based Medi-Cal Administrative Activities Manual, Section 5 (available at www.dhs.ca.gov/maa/webpages-section-units), for direction on how to account for time spent by case managers who are also participating in the LEA Medi-Cal Billing Option Program.

X. *Transportation Policy and Billing*

Q49. Can we bill for transportation to/from a covered service that we are not claiming? For example, the student is being transported to the County Office of Education (COE) for physical therapy service, which is authorized in the IEP. The COE is claiming for the physical therapy service.

A. If the child is receiving a covered service on the same day he or she is transported, and both the service and the transportation are authorized in the student's IEP, your LEA may bill for the transportation even if another provider is responsible for billing the covered service. If an LEA bills only for transportation, they should maintain documentation that another covered service was provided on that day at a different venue.

Q50. In order to bill Medi-Cal for non-emergency medical transportation services provided in a wheelchair van, must students be wheelchair-bound?

A. Yes, in order to bill Medi-Cal for students being transported in a wheelchair van, the student must be transported in a wheelchair.

Q51. Can I only bill for mileage under the LEA Program?

A. No, you cannot bill Medi-Cal for mileage without also billing for the corresponding "flat-rate" transportation. However, you may still bill for allowable non-emergency transportation under the "flat-rate" without billing mileage.

XI. *Documentation and Records Retention Requirements*

Q52. For documentation purposes, is it acceptable for my LEA to present scanned documentation, or must all documentation be presented to State or Federal auditors in its original hard-copy form?

A. No, LEAs must maintain original hard-copy supporting documentation for services rendered for at least three years from the date of service.

Q53. Do we need to distinguish the documentation we maintain for educational purposes versus the documentation for Medi-Cal?

A. Yes. All services rendered and billed to Medi-Cal must meet federal, State and program documentation requirements. Documentation for educational purposes may not fulfill these requirements.

Q54. For an IEP/IFSP student, where should written prescriptions, referrals and recommendations be maintained?

A. For IEP/IFSP students, written prescriptions, referrals, and recommendations can be documented in the student's IEP/IFSP or included as an addendum to the IEP/IFSP. A request for assessment by a parent, teacher, or school nurse must be maintained in the student's files. If your LEA currently uses a physician-based standards protocol for speech and audiology treatment referrals, a copy of the protocol cover letter must be kept in the student's files.

Q55. Does each service encounter need to be documented with progress notes/documentation of services?

A. Yes, CMS' *Medicaid and School Health: A Technical Assistance Guide (August 1997)* indicates that documentation should be maintained on a service-specific basis. In addition, documentation must be created at or near the time of service.

Q56. If the IEP assessment spans several days, what date should be documented for purposes of billing Medi-Cal?

A. When billing Medi-Cal for an assessment that takes multiple days to complete, use the "from-through" billing method to record the dates over which the assessment was conducted.

Q57. What is required for documenting treatment services?

A. Practitioners should write case/progress notes each time the student is treated and save those notes in the student's file. Each service should be documented with the student's name, date of service, practitioner type, and signature. Notes made documenting the service should be consistent with the practitioner's professional standards; this is consistent with *existing* program policy.

Q58. Can licensing and credentialing documentation for practitioners be kept in the LEAs central files?

A. Documentation of licensing and credentialing of practitioners must be accessible for review by State and/or federal agencies. They may be maintained in your central files as long as they are accessible for audit or review.

Q59. How long are we required to retain documentation? Does this time period change if you are under investigation?

A. You must maintain all documentation supporting services rendered for at least three years from the date of service. If your LEA is involved in an audit, review or investigation, all documentation for the audit/review/investigation period must be maintained until the issue is completely resolved. This may mean documentation is retained beyond the three year minimum.

Q60. Are we required to maintain documentation of services provided after the student leaves the LEA?

A. If a student leaves your LEA, you must maintain documentation of services in accordance with the three year minimum retention timeline.

Units of Service and Reimbursement Rates

Q61. Are report writing and other indirect service time accounted for in the new rates?

A. Yes, the new rates account for indirect service costs associated with the direct provision of health services. Your LEA should only bill for *direct* service time.

Q62. I don't understand why I need to record the number of units (e.g., one, two or three units) for 15-45 minute initial treatment services when this whole time period is reimbursed at the same rate, regardless of the number of units?

A. It is imperative that you accurately record the units of initial service, as the units billed to Medi-Cal will be used in the Cost and Reimbursement Comparison Schedule to calculate your LEA's cost to provide services. For initial treatment services billed in 15-45 minute sessions, bill one unit for 15 completed minutes, two units for 30 completed minutes and three units for 45 completed minutes.

Q63. Can we bill LEA, MAA, or both for the time it takes to prepare reports?

A. LEAs may not bill under the LEA Program for report writing. You may only bill for *direct* service time. Preparation of reports, travel time and other administrative activities that are related to the direct provision of health services are not claimable under the LEA Program, as this time was factored into the new LEA interim rate structure. Billing for indirect time would be "double-dipping". In addition, report writing cannot be billed under MAA. For a single service, you may bill *either* MAA *or* LEA, but not both.

Q64. For each LEA reimbursable service, Medi-Cal maximum allowable rates are listed in the Training Workbook. Will we be reimbursed at the Medi-Cal maximum allowable rate?

A. No, you will be reimbursed the Medi-Cal maximum allowable rate *multiplied* by the federal medical assistance percentage (FMAP), which is currently 50%. Note that the FMAP percentage can fluctuate slightly from year to year. In addition, reimbursement is subject to timeliness of claims submission. Reimbursement for claims submitted more than six months after the date of service without a valid delay reason code will be reduced, per the California Welfare and Institutions Code.

XII. *Rebilling*

Q65. What does rebilling mean?

A. SPA 03-024 was effective April 1, 2003. Optional rebilling will be available for services that were originally rendered and billed between April 1, 2003 and July 1, 2006, under the current local code and rate structure. Rebilling these prior claims to obtain the new rates will be contingent upon individual LEAs filing a Cost and Reimbursement Comparison Schedule (CRCS) for the fiscal year they are electing to rebill services. CDHS is working with CMS to develop a rebilling methodology; information on rebilling will be available via the LEA Program Website when a rebilling methodology is finalized.

Q66. Will rebilling be voluntary? What documentation requirement must we fulfill in order to rebill services?

A. Rebilling for services provided after the effective date of the SPA (April 1, 2003) will be a voluntary process. If you choose to rebill, you must meet the new program documentation requirements and submit a Cost and Reimbursement Comparison Schedule for the applicable fiscal year. Future information on rebilling will be available on the LEA Website. Program documentation requirements are located in Section *loc ed a prov* of the updated LEA Provider Manual, as well as in each individual services section of the updated LEA Provider Manual (e.g., *loc ed serv spe* for speech therapy services).

XIII. *Eligibility Verification and Claim Form Completion*

Q67. When completing a claim, is there a specific order in which the modifiers should be recorded?

A. The type of service, practitioner type and IEP/IFSP modifiers can be listed in any order; however the appropriate HCPCS/CPT procedure code must be listed first. When entering modifiers, do not include hyphens or spaces. Enter the first and second modifiers in the HCPCS/Rates Field (Box 44) on the UB-92 Claim Form, when applicable. If there are more than two modifiers, remaining modifiers are entered in Box 49. More detailed information is available in the *loc ed bil ex* and *ub comp op* sections of the LEA Provider Manual.

Q68. Can you bill more than one service on a single claim form per student?

A. Yes, the procedure codes and modifiers will differentiate the services provided, as well as the rendering practitioner, if applicable.

Q69. For "from-through billing", do the dates of service have to be consecutive?

A. No, the dates do not need to be consecutive, but you can only bill one type of service per "from-through" claim line.

Q70. Where can LEA providers get the ICD-9 codes for the diagnosis code box on the UB-92 Claim Form?

A. LEA providers may obtain the *International Classification of Diseases, 9th Revision, Clinical Modifications* (ICD-9) code book from:

Ingenix
P. O. Box 27116
Salt Lake City, UT 84127-0116
1-800-INGENIX (464-3649), 1-800-765-6588 (Customer Service), or

PMIC (Practice Management Information Corporation)
Order Processing Department
4727 Wilshire Blvd., Suite 300
Los Angeles, CA 90010-3894
1-800-MED-SHOP (633-7467) Monday-Friday 8:30 a.m. – 5:00 p.m. (CST)

Q71. Is there an LEA-specific ICD-9 code that should be used on all LEA claims?

A. No. The ICD-9 diagnosis code should be appropriate to the medical diagnosis or covered service the student receives to support the service.

Q72. When my LEA verifies eligibility on the internet, do we need to have the student's Beneficiary Identification Card (BIC) number to check eligibility?

A. Yes; however, if you don't have the student's BIC number, you can use another eligibility determination method, such as the Memorandum of Understanding or the LEA Tape Match option.

Q73. Can we check eligibility with a student's SSN?

A. Currently, you can still verify eligibility using SSN via the Memorandum of Understanding. However, this may change in the future due to HIPAA requirements.

Q74. How long does it take for EDS to process a claim?

A. Electronic claims are generally processed in seven to 10 days; clean hardcopy claims are generally processed within 30 days of submission.

Q75. What happens if my LEA loses its PIN number for the online eligibility verification option?

A. You may go to the Medi-Cal Website at www.medi-cal.ca.gov, select the Provider Enrollment link, and download the application under the "Forms" Section. Your LEA will need to complete a new application and note that a confirmation of the existing PIN is needed.

Q76. How can I obtain a student's Medi-Cal Beneficiary Identification Card (BIC) number?

A. The student's BIC contains the 14-digit alphanumeric BIC number. However, if the card is not available, your LEA can obtain the BIC number using the LEA Tape Match system or a Memorandum of Understanding (MOU) with the county welfare department.